PRINTED: 09/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495356 B. WNG			С		
NAME OF P	ROVIDER OR SUPPLIER	43336	J. VIII.G	070557 1000500 1000500	09/06/2018
TOTAL OF T	NOVIDER OR SUPPLIER		ĺ	STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE	HALL BLACKSBURG			3610 SOUTH MAIN STREET	
		···		BLACKSBURG, VA 24060	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000 E 001 SS=C	An unannounced Em survey was conducted Significant Correction complaince with 42 C Requirement for Long census in this 194 be survey. Establishment of the Establishment of the Establishment of the CFR(s): 483.73 The (facility, except for comply with all application of the Establishment of E	FR Part 483.73, p-Term Care Facilities. The sed facility was 118 during the Emergency Program (EP) or Transplant Center) must able Federal, State and local ness requirements. The hand maintain a gency preparedness program be limited to, the following 2.15:] The hospital must able Federal, State, and aredness requirements. The hand maintain a gency preparedness be requirements of this limited to, the following sency preparedness be requirements of this limited to and maintain a gency preparedness requirements. The default of the series of th	€ 00	Corrective Action(s): The Emergency plan has been reviewed and the Policy and Procedure for providing pharmaceutical supplies for patients and staff as well as the policy a procedure for providing sewer and wast disposal. A facility Incident and Accide form has been completed for this incide	nd c nt nt t k an ing
	Based on staff intervi	ews, the surveyor		Completion Date: 10/19/18 Administratif	
ABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		THE	(XB) DATE
April	tre			Administrated	9/28/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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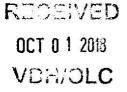
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING_ C 495356 B. WING 09/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3810 SOUTH MAIN STREET **HERITAGE HALL BLACKSBURG BLACKSBURG, VA 24060** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 001 Continued From page 1 E 001 determined that the facility's emergency plan did not address the following areas: 1. That the emergency plan included policies and procedures for the provision of pharmaceutical supplies for patients and staff. 2. Documentation that the emergency plan includes policies and procedures to provide sewage and waste disposal. 3 Documentation of the annual tabletop exercise The surveyor met with the administrator on 9/6/18 at 2 pm in the administrator's office and discussed the above areas of concerns. The administrator stated, "We are scheduled to have the tabletop exercise on 9/11/18." F 000 | INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 9/4/18 through 9/6/18 Five complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 194 certified bed facility was 118 at the time of the survey. The survey sample consisted of 27 current Resident reviews and four closed record reviews F 578 Request/Refuse/Dscntnue Trmnt; Formite Adv Dir F 578 SS=D CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

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Facility ID: VA0107

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495358	1	LE CONSTRUCTION	(X3) DA COI	TE SURVEY MPLETED C
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET BLACKSBURG, VA 24060		9/06/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	§483.10(c)(8) Nothin construed as the right the provision of medi services deemed me inappropriate §483.10(g)(12) The frequirements specific subpart I (Advance Edit) These requirement inform and provide with resident's option, form (ii) This includes a wifacility's policies to in and applicable State (iii) Facilities are perfentities to furnish this legally responsible for requirements of this requirements of this requirements of this wifacility is not information or articulties are cutted an advance did individual's resident with State Law. (v) The facility is not provide this information to the appropriate time. This REQUIREMEN' by: Based on staff intentieview, the facility states.	g in this paragraph should be tof the resident to receive cal treatment or medical dically unnecessary or acility must comply with the ed in 42 CFR part 489, birectives), to include provisions to ritten information to all adult the right to accept or refuse eatment and, at the mulate an advance directive eithen description of the information but are still or ensuring that the section are met, and is incapacitated at the dis unable to receive at whether or not he or she ance directive, the facility rective information to the representative in accordance refleved of its obligation to on to the individual once he invested in place to provide a individual directly at the	F 57	F578 Corrective Action(s): Residents #43 has had their DDI reviewed by the DON and the at physician and it has been update correctly completed to reflect re #43's code status. An Incident a Accident form was completed for incident. Identification of Deficient Practice Action(s): All other residents may have been potentially affected. The Admiss Director and/or Social Services I will review all resident's medicate on the DDNR is accurated out. Any negative findings will rehe Admission Director and/or Services Director to contact all responsible parties to verify each resident's code status and advant directives to insure that the prophas been explained and that writt notification has been placed in the medical record.	ed and sident and or this ctice(s) & ctice(s	

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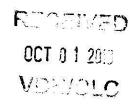
1	DIATELIENE		DICKID SERVICES				OM	IB NO. 0938-0391
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 "		CONSTRUCTION	(хэ	DATE SURVEY COMPLETED
			495356	B. WING				C
l	NAME OF P	ROVIDER OR SUPPLIER		10,00		TREET ADDRESS, CITY, STATE, ZIP CODE		09/06/2018
I	1.100 to one of the				21000			
ı	HERITAGI	E HALL BLACKSBURG				618 SOUTH MAIN STREET		
l	W4) (O	SI MILLADY CY				LACKSBURG, VA 24060		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	220	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	0 8E	(X5) COMPLETION DATE
		Resuscitate) for 1 of 3 sample (Resident #43 The findings included: The facility failed to ha accurate DDNR (Dural Resident #43. Resident #43 was read 4/16/18 with the follow limited to heart failure, diabetes, anxiety disorpsychotic disorder. Or (Minimum Data Set) will Reference Date) of 7/1 as having a BIMS (Bries Status) score of 3 out of Resident #43 was also dependent on 1 or 2 st personal hygiene and the sample of the sample	it residents in the survey it residents in the survey ive a complete and ble Do Not Resuscitate) for dmitted to the facility on ing diagnoses of, but not high blood pressure, der, depression and in the quarterly MDS ith ARD (Assessment 7/18, coded the resident if Interview for Mental of a possible score of 15, coded as being totally aff members for dressing.	F	578	Systemic Change(s): The Facility policy and procedure a reviewed and no changes are warrathis time. The Admissions Director been inserviced on the proper compof a DDNR and Advance Directive required. The Admission Director a discuss with each future Admission advance directors and resuscitation upon admission to the facility. Any/concerns expressed will be reported Administrator. The Administrator & Director of Nursing will speak to concerned or with questions about e area & follow through on all concernes are proper resuscitation status is reflected in the medical record. Monitoring: The Admission Director and Social Services Directorare responsible for maintaining compliance. The Admission Director T	nted at has letion s when vill their status all to the hose ach is to	
		on Resident #43 on 9/5 was noted by the surve for 11/21/17 was not fill Section 1 of the DDNR certify [must check 1 or 1. The patient is CAP informed decision 2. The patient is INCA informed decision"	5/18. During this review, it eyor that the DDNR dated ed out completely. read in part, "I further 2): ABLE of making an APABLE of making an			Director and/or Social Service Direct will audit all Residents medical reconnonthly to monitor compliance for having a current resuscitation order a advance directive Any/all negative findings will be reported to the Administrator for immediate correctivation to include an investigation. Completion Date: 10/11/18	or ds nd/or	
		The boxes beside #1 are The surveyor notified the 2/5/18 at 5:08 pm in the above documented find	e administrative team on conference room of the					

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PRINTED: 09/19/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495356 B. WING 09/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET HERITAGE HALL BLACKSBURG **BLACKSBURG, VA 24060** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 578 | Continued From page 4 F 578 No further information was provided to the surveyor prior to the exit conference on 9/6/18. F 580 Notify of Changes (Injury/Decline/Room, etc.) F 580 SS=D | CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; F580 consult with the resident's physician; and notify. Corrective Action(s) consistent with his or her authority, the resident Resident #91's attending physician has representative(s) when there isbeen notified that facility failed to notify (A) An accident involving the resident which the physician of low blood pressures on results in injury and has the potential for requiring multiple occasions as ordered. A Facility physician intervention; Incident & Accident form has been (B) A significant change in the resident's physical. completed for this incident. mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial **Identification of Deficient Practices** status in either life-threatening conditions or & Corrective Action(s): clinical complications): All other residents with physician ordered (C) A need to alter treatment significantly (that is, daily or weekly blood pressure orders a need to discontinue an existing form of may have potentially been affected. The treatment due to adverse consequences, or to DON, Unit Manager, OA Nurse will commence a new form of treatment); or complete a 100% review of all residents (D) A decision to transfer or discharge the with physician ordered blood pressure resident from the facility as specified in monitoring to identify resident at risk. All §483.15(c)(1)(ii). negative findings will be corrected at the (ii) When making notification under paragraph (q) time of discovery and the attending (14)(i) of this section, the facility must ensure that physician will be notified. A facility all pertinent information specified in §483.15(c)(2). Incident & Accident form has been is available and provided upon request to the completed for this incident. (iii) The facility must also promotly notify the resident and the resident representative, if any,

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when there is-

(A) A change in room or roommate assignment

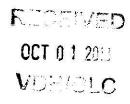
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph

as specified in §483.10(e)(6); or

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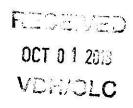
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:		1.50 N.50	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495356	B. WING	200		C 09/06/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG				3610	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH MAIN STREET CKSBURG, VA 24060	1 03/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	100	(XS) COMPLETION DATE
F 580	(e)(10) of this section (iv) The facility must in update the address (in phone number of the representative(s). §483.10(g)(15) Admission to a compitation to a composite dine section to a compitation to a composite dine section that is a composite dine section that is a composite dine section that comprise part, and must specificate room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff interview, the facility staphysician of a change residents in the survey. The findings included the facility staff failed change in condition a pressures for Resident #91 was read/15/15 with the following that the following included disorder and depress (Minimum Data Set) (Minimum Data Set) (Reference Date) of 8 having short term and problems with being and making daily decision coded as requiring exited.	record and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced riew and clinical record aff failed to notify the e in condition for 1 of 31 by sample (Resident #91). it: d to notify the physician of a is related to low blood int #91. admitted to the facility on wing diagnoses of, but not pressure, dementia, anxiety into. On the quarterly MDS with an ARD (Assessment /14/18 coded the resident as	F	580	Systemic Change(s): The facility policy and procedure habeen reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source docume communicating changes in conditions tatus, proper notification to the atter physicians and the responsible particle revision/updates to the comprehensing plan of care. The 24 Hour Report with reviewed and initialed daily by the Administrator, DON and Unit Manager. The Licensed staff will be inserviced by the DON and/or Region nurse consultant on the Notification Rights & Services and issued a copy the facility policy and procedure. To inservice will include staff education Physician and RP notification for an change in resident status, medication treatments. Monitoring: The DON and Unit Managers are responsible for maintaining compliance weekly MAR audits will be compleweekly for residents with physician ordered blood pressure monitoring to monitor compliance. All Any/all nefindings will be corrected at time of discovery and appropriate disciplina action taken. Aggregate findings will reported to the QA Committee for reanalysis and recommendation for chin facility policy, procedure and/or practice. Completion Date:	nt for n, nding es and ve ill be onal of / of he n on ey ns, ted ogative liry li be eview,	

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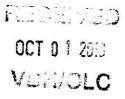
	O TOTA MEDIONICE G	MICDIONIO OCIVIOCO			CMID NO. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 20	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495356	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER	10000		TOTAL TOTAL CONT. AND THE TIP BOOK	09/06/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH MAIN STREET	
HERITAGI	E HALL BLACKSBURG			LACKSBURG, VA 24060	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	being totally dependent bathing. The surveyor perform	e 6 ent on 1 staff member for ned a review of Resident on 9/5 and 9/6/18. During	F 580		
	this review, the surve which stated, "Blood daily". The physician The surveyor reviews were obtained and the were not reported to 9/4/18 10:58 am	yor noted a physician order, pressures to be obtained dated this order for 2/17/17, and the blood pressures that e following blood pressures the physician: 91/60			
	8/24/18 11:42 am 8/7/18 02:19 pm 8/5/18 09:59 am 7/26/18 11:04 am 7/19/18 10:11 am 7/18/18 12:28 pm	96/63 64/41 99/67 96/80 89/73 98/72			
	7/13/18 09:48 am 6/29/18 10:53 am 5/26/18 10:09 am 5/24/18 09:54 am 5/10/18 09:41 am 5/5/18 10:47 am 5/4/18 09:49 am	87/52 95/65 96/68 98/68 98/62 90/62 93/63			
		the administrative team on the above documented			
	stated to the surveyo blood pressures for the asked the DON if the should had been report DON stated, "I would assess the resident for physician." The surveyor blood blood the stated of the surveyor the surveyor blood bloo	e director of nursing (DON) r that she had reviewed the his resident. The surveyor se low blood pressures orted to the physician. The expect the nurses' to rom head to toe then call the eyor asked the DON if there if a head to toe assessment			

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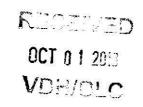
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
495356	B. WING		C 09/06/2018	
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IRG] 3	610 SOUTH MAIN STREET		
	E	SLACKSBURG, VA 24060		
RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
page 7 he nurses' notes on the dates the were low. The DON stated, "No, y."	F 580			
nation was provided to the the exit conference on 9/6/18. y/Confidentiality of Records h)(1)-(3)(i)(ii)	F 583			
acy and Confidentiality. Is a right to personal privacy and it his or her personal and medical ersonal privacy includes are medical treatment, written and munications, personal care, visits, if family and resident groups, but quire the facility to provide a each resident. The facility must respect the personal privacy, including the in his or her orat (that is, spoken), and promptly receive unopened etters, packages and other red to the facility for the resident, delivered through a means other rivice. The resident has a right to secure personal and medical records the right to refuse the release medical records except as		F583 Corrective Action: Resident # 12's RP was notified that facility staff and a facility vendor fai knock on resident's door prior to wa into room to inspect equipment. A faincident and Accident Form was completed for this incident. Identification of Deficient Practice Corrective Action(s): All residents may have been potential affected. A 100% observation auditoresidents will be conducted by the Services, Activity and Nursing Administration to identify any residents for staff and vendors not maintator respecting resident privacy while their resident rooms. Any/all negatifindings will be corrected at time of discovery and staff involved will recimmediate inservice training. An Ind. Accident Form will be completed any/all incidents of exposure.	iled to Iking acility e(s) & ally of all ocial ents at aining in ve	
	A95366 R JRG RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) page 7 the nurses' notes on the dates the were low. The DON stated, "No. ry." mation was provided to the of the exit conference on 9/6/18. ry/Confidentiality of Records th)(1)-(3)(i)(ii) acy and Confidentiality. Is a right to personal privacy and if his or her personal and medical ersonal privacy includes is, medical treatment, written and nunications, personal care, visits, if family and resident groups, but quire the facility to provide a each resident. The facility must respect the of personal privacy, including the in his or her orat (that is, spoken), ctronic communications, including if and promptly receive unopened etters, packages and other red to the facility for the resident, delivered through a means other rivice. The resident has a right to secure personal and medical records. The resident has a right to secure personal and medical records. The resident has a right to secure	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495366 R JRG RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL IY OR LSC IDENTIFYING INFORMATION) Page 7 The nurses' notes on the dates the were low. The DON stated, "No. by." Ination was provided to the other exit conference on 9/6/18. I//Confidentiality of Records This or her personal privacy and if his or her personal and medical President, and the facility must respect the personal privacy, including the in his or her orat (that is, spoken), ctronic communications, including and promptly receive unopened enters, packages and other red to the facility for the resident, delivered through a means other revice. The resident has a right to secure personal and medical records has the right to retuse the release medical records except as 3.70(i)(2) or other applicable (X2) MULTIPLE A. BUILDING A. BUILDING B. WING PREFIX TAG F 580 F 580 F 580 F 583 F 584 F 583 F 583 F 584 F 583 F 585 F 585 F 586 F 586 F 587 F 587 F 587 F 588 F 589 F 580 F 580	X11 PROVIDER/SUPPLIER/CLA 10 PROVIDER/SUPPLIER/CLA 495368 STREET-ADDRESS, DITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET BLACKSBURG, VA 24080 BY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC DENTIFYING INFORMATION Page 7	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495356	B. WING		01	C /06/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET BLACKSBURG, VA 24060	<u> </u>	100/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OUID 8E	(X5) COMPLETION DATE
F 583	to examine a resident administrative recordilaw This REQUIREMENT by: Based on observation document review, the service vendor failed for 1 of 31 Residents Resident # 12. The findings included A facility staff membe vendor failed to knock prior to entering her of the services vendor entering the services vendor enterior to entering the services vendor enterior to entering the respiratory service Resident # 12's room the respiratory service without knocking on the respiratory service to entering the room. On 9/4/18 at 12:38 printo Resident # 12's room to entering the room. On 9/6/18 at 8:12 am the facility administrator member and respirator Resident # 12's room entering the room. The administrator if outsident services records.	ng-Term Care Ombudsman I's medical, social, and is in accordance with State is not met as evidenced in, staff interview, and facility if facility staff and respiratory to respect Resident privacy in the survey sample, r and respiratory service k on Resident # 12's door oom. n, the surveyor was in conducting an interview. interview, a respiratory red Resident # 12's room he door prior to entering. tes vendor checked p machine. n, a facility employee walked oom without knocking prior	F 54		are and ms will be es director s, rivacy to ting Social e for DON. o weekly he facility ce. Any/all ected action will gate ee Quality iew. ns for and/or	

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Facility 10: VA0107

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PRINTED: 09/19/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 495356 B. WING 09/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET HERITAGE HALL BLACKSBURG **BLACKSBURG, VA 24060** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 583 | Continued From page 9 F 583 providing services to the facility. The facility administrator stated to the surveyor that the outside vendors are held to the same standards as the facility employees and this had been outlined within their contract. On 9/6/18 at 12:55 pm, the facility administrator provided the surveyor with a copy of the Respiratory services contract. The contract contained information that included but was not limited to: ... "All of the above listed services shall be conducted by the Vendor in accordance with recognized professional and ethical medical standards within terms and conditions of this Agreement and any and all applicable rules. regulations, policies and procedures of (cooperation's name withheld) including , but not limited to, the (cooperation's name withheld) Policy and Procedure Manual, and all subsequent amendments thereto (all of which are hereby incorporated by reference), and all applicable state, federal and local laws, rules and regulations." ... According to the facility policy on "Quality of Life -Dignity," the policy interpretation and implementation contains documentation that includes but is not limited to: "6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms."

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Quality of Care

CFR(s): 483.25

F 684

SS=E

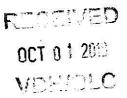
No further information was provided to the survey team prior to the exit conference on 9/6/18.

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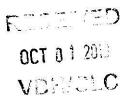
A. BUILDINGCOMPL	
495356 B. WNG) 6/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1610 SOUTH MAIN STREET BLACKSBURG, VA 24060	10/2018
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 Continued From page 10 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for 2 of 31 residents in the survey sample (Resident # 33 and Resident #70). The findings included: 1. The facility staff failed to follow professional standards of care regarding documentation of administration times for insulin for Resident #3.3. Resident #33 was admitted to the facility on 4/2/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, diabetes, Alcheimer's disease, dementia, anxiety discorder and depression. On the significant change, MDS (Minimum Data Set) with ARD (Assessment of Reference Date) of 7/9/18 the resident was coded as having short term and long-term memory problems and was moderately impaired in daily decision-making skills. Resident #33 was also coded as being totally dependent on 1 or 2 staff members for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #33% clinical record on 9/5 and 9/6/18. During	

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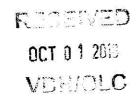
	VIDER/SUPPLIER/CLIA REPORTION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495356	B. WING		C	
NAME OF PROVIDER OR SUPPLIER	10000	1	TREET ADDRESS, CITY, STATE, ZIP CODE	09/06/2018	
HERITAGE HALL BLACKSBURG		.3	610 SOUTH MAIN STREET ILACKSBURG, VA 24060		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIFICATION OF LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
this review, the surveyor noted physician order on the MAR (NAdministration Record) which: 100 units/ml (milliliter) Flexpen Insulin) as follows: BS (blood (units), Notify MD, 71-150=0 U 181-220=4 U, 221-250=6 U, 2: 301-350=10 U, 351-400=12 U, give 12 U and notify MD" The reviewed the MAR for the monand September 2018. The surveyor notified the direct (DON) and regional nurse condicated: The surveyor for the facility's policy regarding orders and administration. At 2:45 pm, the surveyor received facility's policy titled, "Medication Orders" which read in part as followed as the surveyor of doses, start and specific duration of therapy; c. Dosage and frequency of d. Route of administration No further information was prosurveyor prior to the exit confect at the surveyor prior at the exit confect at the surveyor prior at the exit confect at the surveyor prior to the exit confect at the surveyor prior to the exit confect at the surveyor prior at the sur	Medication stated, "Novolog sSI (Sliding Scale sugar) 0-70=0 U d, 151-180=2 U, 51-300=8 U, 401 or greater the surveyor this of July, August sultant on 9/6/18 at the insulin to be requested a copy g medication wed copies of the on and Treatment follows: ons must include: drug; d stop date, and/or administration; vided to the rence on 9/6/18. low physician's ont or Resident #70. was reviewed on	F 684	Systemic Change(s): The facility policy and procedures heen reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by 24Hour Report and documentation medical record /physician orders ret the source document for the develop and monitoring of the provision of which includes, obtaining, transcrib and administering physician orderer medications and treatments. The DG and/or Regional nurse consultant winservice all licensed nursing staff oprocedure for obtaining, transcribin completing physician medication at treatment orders. To include follow Accucheck and sliding scale insulin orders per physician order. Monitoring: The DON will be responsible for maintaining compliance. The DON ADON and/or Unit Managers will perform weekly MAR audits on al residents with Accucheck and slidis scale insulin orders to monitor for compliance. Any/all negative find or errors will be corrected at time discovery and disciplinary action taken as needed. Aggregate findin these audits will be reported to the Quality Assurance Committee que for review, analysis, and recommendations for change in fapolicy, procedure, and/or practice Completion Date: [7/12/16]	the n the nains oment care, ing d ON ill on the g, and and ring the of sill be args of e arterly acility	

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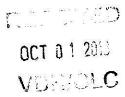
NAME OF PROMOTER OR SUPPLIER HERITAGE HALL BLACKSBURG 0.04) D SEMBARY STATEMENT OF DEFICIENCIES BLACKSBURG, VA 24060 SEMBARY STATEMENT OF DEFICIENCIES BLACKSBURG, VA 24060 PROMOTER SEALO OF CORRECTION RESOLATORY ON LSC IDENTIFYING IN-FORMATION) F 684 Continued From page 12 diabotes, and depression The latest MDS (minimum data set) assessment dated 3/6/18 coded the resident as cognitively unimpared. He required nursing staff assistance for the majority of the ADLs (activities of daily living) Resident #70's CCP (comprehensive care plan) reviewed and revised on 8-8-18, documented his diabetic management interventions under ADLs (Staff interventions included provide medications as ordered, accu-checks and insulin per orders and be alert to any ski hyperitypolycemia. The latest physician's orders, signed and dated on 9/7/18, included, "Accu-checks AC & HS (before meals and hour of sleep) BS (blood sugar) less than 70 or greater than 400 notify physician." The MRR (medication administration record) for August 2018 was reviewed and the resident's blood sugars were observed to be above 400 on three days: 1. 8/6/18 at 4.30 PM = 439 2. 8/18/18 at 4.30 PM = 440 The clinical record did not contain documentation that the accu-checks/fibod sugars had been reported to the physician per has orders. On 9/5/18 at 2.29 PM the DON was asked to provide evidence the physician had been notified of the accu-checks/fibod sugars in question. The	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. 495366			(X2) MULTIPLE A BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HERITAGE HALL BLACKSBURG D(A) 1D FOR PROVIDER STANDERS, CITY, STATE, ZIP CODE BY STREET ADDRESS, CITY, STATE, ZIP CODE BY STATE ADDRESS, CITY, STATE, ZIP CADE CACH STATE CACH CAPPER ADDRESS, CITY, STATE, ZIP CAPPER CACH CAPPER A			B. WING	B. WING		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY				3	610 SOUTH MAIN STREET	1 03/00/2018
diabetes, and depression The latest MDS (minimum data set) assessment dated 8/6/18 coded the resident as cognitively unimpared. He required nursing staff assistance for the majority of the ADLs (activities of daily living) Resident #70's CCP (comprehensive care plan) reviewed and revised on 8-8-18, documented his diabetic management interventions under ADLs Staff interventions included provide medications as ordered, accu-checks and insulin per orders and be alert to any s/s hyper/hypoglycemia The latest physician's orders, signed and dated on 8/7/18, included, "Accu-checks AC & HS (before meals and hour of sleep)	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION
DON said there was no documentation the accu-checks had been reported to the physician	F 684	diabetes, and depress The latest MDS (mining dated 8/6/18 coded the unimpaired. He require for the majority of the living) Resident #70's CCP (reviewed and revised diabetic management Staff interventions income as ordered, accu-ched and be alert to any s/s The latest physician's on 8/7/18, included, "/(before meals and hor sugar) less than 70 or physician." The MAR (medication August 2018 was revisiblood sugars were obthree days: 1. 8/6/18 at 4:30 PM = 2. 8/18/18 at 4:30 PM The clinical record did that the accu-checks/lireported to the physician of the accu-checks/lireported evidence the pof the accu-checks/lirepons and there was revisible DON said there was revisible to the physician of the accu-checks/lirepons and there was revisible to the accu-checks/lirepons and the accu-checks/lirepons and there was revisible to the accu-checks/lirepons and there was revisible to the accu-checks/lirepons and there was revisible to the accu-checks/lirepons and the accu-checks/l	mum data set) assessment the resident as cognitively red nursing staff assistance ADLs (activities of daily comprehensive care plan) on 8-8-18, documented his interventions under ADLs fuded provide medications cks and insulin per orders is hyper/hypoglycemia. orders, signed and dated Accu-checks AC & HS aur of sleep)BS (blood greater than 400 notify administration record) for ewed and the resident's served to be above 400 on 4-439 = 400 = 440 I not contain documentation blood sugars had been ian per his orders. the DON was asked to physician had been notified bod sugars in question. The no documentation the	F 684		

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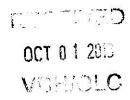
CLILIE	3 FOR WEDICARE OF	INEDICAID SERVICES			OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
	000 Mar W	495366	B WING		C 09/06/2018
NAME OF P	ROVIDER OR SUPPLIER	के देशकेंग का जा का संस्थ		REET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGI	E HALL BLACKSBURG			ID SOUTH MAIN STREET ACKSBURG, VA 24060	
	CI WALANY C	TAWASIA OF DEPOSITIONS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684	Continued From pag	e 13	F 684		
	No additional eviden	ce was provided prior to the	2000		
	survey team exit.	errorete total jedne Errorete (grandestronere de		F695	1
F 695	Respiratory/Tracheo	stomy Care and Suctioning	F 695	Corrective Action(s):	
SS=D	Property - with the recognition of the contract of the contrac	,	5,1406	Resident #62's attending physician v	vas
				notified that the facility administered	
	§ 483.25(i) Respirato	ory care, including		oxygen to resident #62 without a	
	tracheostomy care a	nd tracheal suctioning.		physician order. Resident #62's atten	ding
	The facility must ens	sure that a resident who		physician assessed and clarified resid	lent
		re, including tracheostomy		#62's oxygen order. A facility Incide	
		ctioning, is provided such		Accident form has been completed for	or
	F	professional standards of		this incident.	
		hensive person-centered		The second company of the second	
		nts' goals and preferences,		Identification of Deficient Practice	s &
	and 483.65 of this su	<u> </u>		Corrective Action(s): All residents receiving oxygen therap	
		T is not met as evidenced		have potentially been affected. A 100	
	by:			review of all resident's oxygen order	
		on, staff interview and clinical		be conducted by the DON, ADON ar	
	physician order was	cility staff failed to ensure a		Unit Manager to identify residents at	
		gen for 1 of 31 residents in		Residents found to be at risk will be	
	the survey sample (F	1.57 A		corrected at the time of discovery. A	facility
	i the survey sample (i	vesideni #02).		Incident & Accident form will be con	mpleted
	The findings included	d-I		for each item discovered.	
	go mondo				
	The facility staff to ea	nsure a physician order was		Systemic Change(s):	ļ
		administration of oxygen for	i	The facility policy and procedure for	
	Resident #62.			Oxygen administrationhas been revie	
				and no changes were warranted at the	3
	Resident #62 was ad	dmitted to the facility on		time. All licensed nursing staff will be inserviced on the facility policy and	,c
		wing diagnoses of, but not	1	procedure for accurate oxygen	
		e, high blood pressure,	1	administration and monitoring per	
	The same of the sa	tract infection, diabetes,		physician order.Inservices will include	de the
	stroke, depression a	nd respiratory failure. On the	1	delivery of oxygen per physician ord	30
		num Data Set) with ARD		and the monitoring oxygen flow rate	
		nce Date) of 7/25/18, the		throughout the shift.	
	resident was coded a	as having a BIMS (Brief			
		Status) score of 14 out of a			
	possible score of 15.	Resident #62 was also			i
					1

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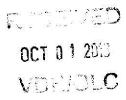
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1855 NA SUBSTITUTE STREET STREET	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495356	B. WING		C 09/06/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBUR	G	31	TREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH MAIN STREET LACKSBURG, VA 24060		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION!	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
member for dressi On 9/6/18 at 8:20 resident's room an receiving oxygen a cannula. At 9:00 a consultant and sur resident's room an receiving oxygen a cannula. The surv consultant reviewe The clinical record for oxygen that the regional nurse cor into this some mor what I find out." At 10:00 am, the re returned to the sur was discharged to readmitted to the forder to restart he No further informa surveyor prior to th Pain Management CFR(s): 483.25(k) §483.25(k) Pain M The facility must e provided to reside consistent with pro the comprehensive and the residents' This REQUIREME by.	ally dependent of 1 staffing and bathing. am, the surveyor went into the dispersed the resident at 4 liters/minute by nasalism, the regional nurse everyor went back into the dispersed the resident at 4 liters/minute by nasality eyor and regional nurse district the resident's clinical recordicted did not have a physician order resident was receiving. The sultant stated, "Let me look and I will get back to you with the hospital and when she was acility, the staff didn't get an exygen."	F 695	Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will perform weekly aud of all residents using oxygen to monito for compliance. All negative findings where the discovery and appropriate disciplinary action will be taken as needed. All negative findings were proted to the Quality Assurance. Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date:	its r vill	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		*****	State		С		
NAME OF B	2014058 22 21 22 152	495356	B. WING		09/06/2018		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HALL BLACKSBURG				- 10	610 SOUTH MAIN STREET BLACKSBURG, VA 24060		
GUINNAPA PATATATATA OF DECOGNOSO							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	to provide pain manage professional standard residents (Resident # Findings: The facility staff failed management in accordand standards of practice (Resident #275). Resident #275 was reviewed on 9/5/ Resident #275 was at 6/7/17 and discharged diagnoses included at hypertension, depression, depressions of the resident did not he (minimum data set) did Resident #275's initia 6/7/17 documented puthis resident. The staff	rse of a complaint etermined facility staff failed gement in accordance with s of practice for 1 of 31 275). I to provide pain rdance with professional for 1 of 31 residents ident #275's clinical record 18 at 3:00 PM. dmitted to the facility on d on 6/10/17. The resident trial fibrillation, diabetes, sion, anxiety, lung mass coronary artery disease and re. have a completed MDS uring her three day stay. I care plan, initiated on ain as a chief concern for ff interventions included	F	697	· · · · · · · · · · · · · · · · · · ·	dress ents sately ent t. es & led or eview d care nts ngs the of any	
	"be alert to & assess for s/s (signs and symptoms) c/o (complaints) of painbe alert to effectiveness of pain medication"				been reviewed and no revisions are warranted at this time. The DON and	/or	
	and dated on 6/9/17, "Fentanyl 25 mcg/hr p days. Rotate sites." T consistent with that us hospital during the re-	itial/admission physician's orders, signed ated on 6/9/17, included an order for anyl 25 mcg/hr patch apply one every three Rotate sites." This medication was tent with that used at the discharging all during the resident's stay there, prior to mission to the nursing home facility.			Regional nurse consultant will inservall licensed nursing staff on the proce for following and administering medications per physician order. This includes reassessing residents after thadministration of routine or PRN pair medications.	dure c	

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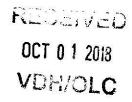
		(X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495356 B. WING		C 09/06/2018		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG		1	STREET ADDRESS, CRY, STATE, ZIP CODE 1610 SOUTH MAIN STREET BLACKSBURG, VA 24060	V3/10/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 697	June 2017 documents Fentanyl 25 mcg/hr p 6/8/17 9 AM. The condocumented, "6/8/17 (Resident's) daughter from home, MD notific fentanyl patch and stamcg/hr apply one patch placed this mort to R upper back w/op MD/RP aware." The nursing notes we documented the residentity on 6/7/17 at 2: assessment conducte patch was verified mirresident denied pain and the placed by hospital state right shoulder. Nuphysician, who ordered to be placed on 6/8/1 orders were received resident's pain in the On 6/7/17 at 10:11 Pt the resident for pain, rating tool with no cordered to the placed of the placed of the placed with no cordered the resident for pain. The nurse staff to the room to rechest pain. The nurse	administration record) for ed the placement of a atch on the resident on responding nursing note at 12:31 PMrsd brought in fentanyl patch ed. New orders, d/c/ current ent apply fentanyl patch 25 ch Q (every) three days, ming approximately 8:30 AM site dressing over in place. The reviewed and dent was admitted to the 49 PM. During an ed at 7:24 PM the Fentanyl esting by nursing staff. The eat that time. It is a patch had been off on the previous day on arising staff notified the ed Fentanyl patch 25 mcg/hr 7 at 9 PM. No additional to address/manage the interim. If the nursing staff assessed They documented the pain implaint or evidence of pain. The nursing notes dent's daughter called the port her mother was having	F 697	Monitoring: The DON will be responsible for maintaining compliance. The DON. ADON and/or Unit Managers will auresident MAR's weekly to monitor for compliance. Any/all negative finding or errors will be corrected at time of discovery and disciplinary action will taken as needed. Aggregate findings these audits will be reported to the Quality Assurance Committee quarte for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 1991 199	or s and be of rly	

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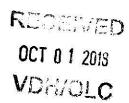
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING C 495356 B. WING 09/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET HERITAGE HALL BLACKSBURG **BLACKSBURG, VA 24060** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 697 Continued From page 17 F 697 No other pain management was provided by nursing staff until the family member arrived with the resident's Fentanyl patch from her home supply at 8:30 AM. The staff did not document pain monitoring between 10:11 PM (on 6/7/17) and 6:24 AM the following day. On 8/5/18 at 2:29 PM the administrator and DON were informed of the surveyor's findings and that the resident's pain had not been managed appropriately after staff realized the Fentanyl patch was missing upon admission from the hospital. No pain management was provided until the resident was reported by a family member to be in acute distress with chest pain the following morning. No additional evidence was provided prior to survey team exit. This was a complaint deficiency. F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 SS=D CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG (74) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE FREGULATORY OR LSC IDENTIFYING INFORMATION) FRETIX TAGE Continued From page 18 F 812 Continued From page 18 F 812 Continued From page 18 F 812 F 812 Corrective Action(s): The Maintenance staff member #1 observed in the kitchen without a hairmet on and other dining server #1 have been inserviced on the proper use of a hair net anytime they enter the kitchen food preparation area. A facility Incident and Accident form was completed for this incident. The dietary staff failed to ensure the walk=in freezer was working appropriately, dietary staff failed to ensure all of their hair was contained in	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		35 35	(X3) DATE SURVEY COMPLETED		
A95356 B. WING			F. SOLDING.		**************************************				
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSBURG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (C4) ID PREFIX TAG CAN ID PREFIX TAG CONTINUED FROM (EACH DEPICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 18 F 812 Continued From page 18 F 812 Continued From page 18 F 812 F 812 F 812 F 812 F 812 Corrective Action(s): The Maintenance staff member #1 observed in the kitchen without a hairned on and other dining server #1 have been inserviced on the proper use of a hair net anytime they enter the kitchen food preparation area. A facility Incident and Accident form was completed for this incident. The dietary staff failed to ensure the walk=in freezer was working appropriately, dietary staff failed to ensure all of their hair was contained in	495356		B. WNG						
RENTAGE HALL BLACKSBURG BLACKSBURG, VA 24060	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREVIOUS TAG PREPROPERTY PREFIX TAG PREVIOUS TAG PREFIX TAG PREVIOUS TAG PREPROPERTY PREFIX TAG PREVIOUS TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREVIOUS TAG PREFIX TAG PREVIOUS TAG PREVIOUS TAG PREFIX TAG PREVIOUS TAG PREFIX TAG PREVIOUS TAG PREVIOUS TAG PREVIOUS TAG PREFIX TAG PREVIOUS TA	MEDITAGE MALL DI ACKEDIDO				3610 SOUTH MAIN STREET				
F 812 Continued From page 18 F 812 Continued From page 18 F 812 F 812 Continued From page 18 F 812 F 812 F 812 Corrective Action(s): The Maintenance staff member #1 observed in the kitchen without a hairnet on and other dining server #1 have been inserviced on the proper use of a hair net anytime they enter the kitchen food preparation area. A facility Incident and Accident form was completed for this incident. The dietary staff failed to ensure the walk=in freezer was working appropriately, dietary staff failed to ensure all of their hair was contained in	HERITAGE HALL BLACKSBURG			BLACKSBURG, VA 24060					
S483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The findings included: The dietary staff failed to ensure the walk=in freezer was working appropriately, dietary staff failed to ensure all of their hair was contained in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	TTD BE	DIBE COMPLETION		
the hairnets, and failed to ensure the 400 hall pantry was clean The surveyor entered the kitchen on 9/5/18 at 11:21 a.m. to check tray line temperatures. The surveyor observed the maintenance staff #1 standing on the opposite side of the tray line talking with a dining server. The maintenance staff #1 did not have a hairnet covering his hair. In addition, while in the kitchen, the surveyor observed two dining servers with strands of long hair hanging out from under their hairnets. One of the dining servers (#1) was observed trying to contain her hair in the hairnet. The surveyor asked what she should do after she put her hair back in the hairnet and she stated, "I'm going to wash my hands" and proceeded to the sink to do so. The surveyor also observed one of the dining servers (#2) attempting to open the walk-in freezer door and was having much difficulty in	F 812	§483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation facility staff failed to serve food in accorda standards for food se The findings included. The dietary staff failed freezer was working a failed to ensure all of the hairnets, and failed pantry was clean. The surveyor entered 11:21 a.m. to check the surveyor observed the standing on the oppostalking with a dining set staff #1 did not have in addition, while in the observed two dining shair hanging out from of the dining servers contain her hair in the asked what she should back in the hairnet ar wash my hands" and so. The surveyor also observers (#2) attemptions.	prepare, distribute and ance with professional revice safety. I is not met as evidenced an and staff interview, the store, prepare, distribute and ance with professional revice safety. It do ensure the walk=in appropriately, dietary staff their hair was contained in ed to ensure the 400 hall If the kitchen on 9/5/18 at ray line temperatures. The emaintenance staff #1 site side of the tray line server. The maintenance a hairnet covering his hair. The kitchen, the surveyor servers with strands of long a under their hairnets. One (#1) was observed trying to be hairnet. The surveyor lid do after she put her hair and she stated, "I'm going to proceeded to the sink to do served one of the dininging to open the walk-in	F 81	Corrective Action(s): The Maintenance staff member observed in the kitchen without on and other dining server #1 ha inserviced on the proper use of a anytime they enter the kitchen for preparation area. A facility Incidence Accident form was completed for incident. The walk-in freezer identified we build-up during the kitchen tour inspected by the maintenance de and completely defrosted. A facility incident and Accident form was completed for this incident. The 400 hall pantry identified we strong odor has been thoroughly by environmental staff. A facility and Accident form was completed incident. Identification of Deficient Prace Corrective Action(s): All other residents may have been potentially affected. The Food Schanager, and/or Registered Diet randomly monitor the kitchen prace a before, during and after meanidentify any negative findings. A negative findings will be corrected time of discovering and disciplinaction will be taken as need. Environmental services will perfected and Accident form will completed for each of negative findings in the completed for each of negative findings will completed for each of negative findings will completed for each of negative findings.	a hairnet tive been a hair net bood dent and or this ith ice has been spartment dilty ith a cleaned y Incident ed for this etices & en ervice dician will eparation als to any ed at the eary form daily cility be			

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No further information was provided prior to the exit conference on 9/6/18.

9/6/18 at 5:15 p.m.

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bonnet

build=up. She stated she had educated the staff and stated the kitchen staff may have to go to a

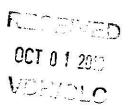
The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern during the end of the day meeting on

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STATEMENT OF DEFICIENCIES IX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 0 B. WING 495356 09/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTH MAIN STREET HERITAGE HALL BLACKSBURG BLACKSBURG, VA 24060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Infection Prevention & Control F 880 F880 CFR(s): 483.80(a)(1)(2)(4)(e)(f) SS=D Corrective Action(s): The medical director was notified that the §483.80 Infection Control facility failed to implement a The facility must establish and maintain an comprehensive infection control program infection prevention and control program and failed to accurately complete designed to provide a safe, sanitary and infection control tracking logs. A facility comfortable environment and to help prevent the Incident & Accident form has been development and transmission of communicable completed for this incident. diseases and infections. The contract respiratory services vendor §483.80(a) Infection prevention and control staff have been inserviced by the DON on program. the possible indirect-transmission of The facility must establish an infection prevention infectious agents by their clothing and and control program (IPCP) that must include, at equipment being placed on or touching a minimum, the following elements: multiple resident beds. An Incident & Accident form was completed for each §483.80(a)(1) A system for preventing, identifying, incident. reporting, investigating, and controlling infections and communicable diseases for all residents. Identification of Deficient Practice(s) staff, volunteers, visitors, and other individuals and Corrective Action(s): providing services under a contractual All other residents may have potentially arrangement based upon the facility assessment been affected. A 100% review of all conducted according to §483.70(e) and following residents with infections will be accepted national standards: conducted by infection control nurse to identify whether the status of the §483.80(a)(2) Written standards, policies, and infections was being appropriately procedures for the program, which must include, monitored, listed on the infection control but are not limited to: tracking logs to monitor for trends, improvement, ongoing treatment or if (i) A system of surveillance designed to identify they have been resolved. Any/all negative possible communicable diseases or infections before they can spread to other findings related to isolation precautions and infection control tracking and persons in the facility; trending will be corrected at time of (ii) When and to whom possible incidents of discovery and a facility Incident & communicable disease or infections should be Accident form will be completed. reported: (iii) Standard and transmission-based precautions to be followed to prevent spread of infections: (iv)When and how isolation should be used for a

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resident; including but not limited to

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nursing services

1. During the entrance conference on 9/4/18 the surveyor requested the infection control line list (tracking form for facility infections) from July 2017 through July, 2018 from the director of

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB N	NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495356	B. WING		۱ ,	C 9/06/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		3,00,2010
			3	610 SOUTH MAIN STREET		
HERITAG	E HALL BLACKSBURG			BLACKSBURG, VA 24060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From paç	ge 22	F 880			
	infection control nur- control line listing for months. The survey did not have a resolu- had been resolved of infection. The infecti- just started this job a information can easi this will be complete. At 4:20 pm, the regi- notified of the above regional nurse consi- with or without an in- the past year. The in- here now just started	on, the surveyor and the se reviewed the infection of for the above documented for noted that the line listing ution of each infection if they or continued to be ongoing tion control nurse stated, "I about a month ago. But this illy be put in a column so that e going forward." conal nurse consultant was a documented findings. The ultant stated, "We have been fection control nurse that is diabout a month ago."				
	surveyor prior to the 2. Contracted respir observed by the sur	exit conference on 9/6/18. ratory Services vendors were veyor placing their clipboards residents' bed while servicing				
	room conducting an respiratory services while the interview v service the respirator surveyor observed the vendors place their conductions.	om, the surveyor was in a interview with a resident. The vendors came into the room was being conducted to by care equipment. The he respiratory service clipboards and backpack on ate's unoccupied bed while the equipment.				
	the facility administr	n, the surveyor spoke with ator and made him aware of d above. The facility				

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